MEDICAL COUNCIL OF MALAWI

DATA VERIFICATION FORM

PERSONAL DETAILS

FIRST NAME: _____ SURNAME: _____

MAIDEN NAME: _____ OTHER NAMES _____

GENDER: ☐ Male ☐ Female _ NATIONALITY: _____

NATIONAL IDENTITY NUMBER(PLEASE ATTACH COPY) _____ EMPLOYMENT NUMBER _____

CURRENT ADDRESS: _____

DATE OF BIRTH _____ EMAIL:1 _____

PHONE # 1 _____ PHONE # 2 _____ EMAIL2 _____

CURRENT FACILITY (Where you are working)

FACILITY NAME: DATE JOINED

CURRENT CADRE REGISTRATION DETAILS(PLEASE ATTACH COPIES)

CADRE NAME: _____

CURRENT REG. NUMBER: **MCM/** _____ REGISTRATION DATE: _____

PRIVATE PRACTICE NUMBER **MCM/** _____ REGISTRATION DATE: _____

PREVIOUS REG. NUMBER: **MCM/** _____ REGISTRATION DATE: _____

QUALIFICATION: _____

TRAINING INSTITUITION _____ YEAR _____

HIGHEST/ OTHER QUALIFICATION: _____

TRAINING INSTITUITION YEAR

CURRENT STATUS (Tick where appropriate)

☐ Practicing ☐ In Training ☐ Overseas ☐ Office ☐ Other

AMOUNT PAID MK..... AMOUNT OWING MK..... TOTAL ARREARS MK.....

OFFICIAL USE ONLY

ELIGIBLE TO RENEW YES ☐ NO ☐ IF NO, LAST RENEWAL YEAR _____

MCM REGISTRY OFFICER VERIFYING ..... SIGNATURE .....
DATE: